

INCIDENT REPORTING – COMMUNITY RECOVERY SERVICES—INSTRUCTIONS

I. Which Programs Require Incident Reporting Using this Form?

The incident reporting system described here is used in the Community Recovery Services benefit.

II. Contact Information

Designee	Contact and Fax Number
• Community Recovery Services	Coordinator Fax - 608-267-7793

III. Who Must Report Incidents?

Incident reporting is expected of all of the actors in the system including Medicaid agencies, providers, and also CRS participants, families and guardians. The actual reports to the department on the required forms are the responsibility of the Medicaid agency or people or agencies designated by the Medicaid agency as responsible for reporting to the Department. Reports from other parties will generally route through the Medicaid agency staff (e.g., support and service coordinators) but need not be on the required forms. The Medicaid agency is responsible for ensuring that its staff are assigned this responsibility or that an agency is designated to perform this function and that reporting occurs for all reportable incidents involving each and every CRS participant.

Medicaid agencies will typically assign this expectation to support and service coordinators for their assigned CRS participants. These Medicaid agency staff will typically be responsible for writing up and submitting the report or for reviewing reports submitted by provider agencies. It is suggested that Medicaid agencies have a single manager to serve as a point of contact to coordinate incident reporting to promote consistency and reduce errors. Medicaid agencies may use any model for organizing this aspect of their response system so it can address the size, geography, organization or other factors relating to that agency. The system must also accommodate the use of self-directed services.

All providers who serve CRS participants are also covered by the requirement to report incidents. They are not required to use the DHS forms unless directed to do so by the Medicaid agency. This includes provider agencies, agency staff, individuals who serve as independent providers not affiliated with an agency, and providers of self-directed services. These individuals must also report incidents according to the requirements specified here. Providers must make these reports to Medicaid agencies, and should not directly report to the Department. Providers may also have other legally required reporting requirements related to an incident under child and adult protective service laws or as a condition of licensing. **Reporting incidents under CRS does not relieve providers of any other reporting obligations.**

In addition to Medicaid agencies and service providers, CRS participants, parents, guardians and members of the CRS participant's family can also report incidents to the Medicaid agency. These reports can be in the form of an e-mail, letter or verbal report via telephone or in person or may use the incident reporting form. Use of the DHS form is not required or recommended. Parents and guardians should be informed of this option and given the brochure prepared for their use explaining how and to whom to report. Medicaid agencies should give them the contact information of designated staff to whom they should report. Reports by parents should be directed to support and service coordinators, but will be accepted and acted upon by state staff if the report comes directly to the state.

IV. What Incidents Must Be Reported?

Reportable incidents are defined as actual or alleged events, situations or conditions that pose a significant immediate and/or ongoing threat or risk to the physical or mental health, safety, well-being or continued community presence of an adult or child CRS participant. Reportable incidents also include the actual or alleged misappropriation of the CRS participant's funds or property or unexpected and unusual adverse environmental conditions that pose serious danger to the participant's health or welfare. Reportable incidents are always unanticipated.

Reportable incidents do not include the provision of health care services or behavior interventions made necessary by previously known illness or conditions or behavior previously exhibited by the CRS participant if the illness, condition or behavior has occurred in the past and can and/or should have been anticipated to reoccur episodically. For example, trips to an emergency room to deal with a serious, known, chronic medical condition are not reportable incidents, while a serious injury due to a car accident is and must be reported. An episode of challenging behavior that is already the subject of a behavior intervention plan is not a reportable incident, while the unanticipated use of restraints not called for in a plan due to behavior not previously observed is a reportable incident. An exception to the “anticipation” consideration involves death; both an unexpected death and a death from a known, long-standing illness are both to be reported as incidents.

Some incidents are considered critical incidents. “Critical Incidents” are active and ongoing events or situations that involve immediate danger or risk to the CRS participant’s health, safety and/or well being. A case of abuse, no matter how bad, is not considered critical if it happened a year ago and the perpetrator is no longer present. While this is a reportable incident, it is NOT a critical incident. Events or situations considered “critical” are happening and present a current risk. These are to be designated as such on the reporting form and should be the subject of immediate notification by the Medicaid agency. Acts, situations or crimes that are not current, and therefore not considered critical, may still be the proper subject of immediate notification if the act represents a serious threat to the life, health, safety and welfare of the CRS participant or others involved with the participant.

The following incidents must be reported to appropriate, designated staff by Medicaid agencies and/or providers:

- Any abuse or neglect of the participant inflicted by others known or suspected.
- All deaths of CRS participants that occur while they are active in the benefit or within 30 days of their termination from the benefit if this is known. (**This does not replace any other death reporting requirements.**)
- Any misappropriation of the person’s funds or property. Misappropriation includes taking the participant’s money or property or using these for the benefit of others and not for the participant. For example, buying cable TV service for a CRS participant who does not watch TV—that is used for the amusement of staff—is misappropriation. Misappropriation also includes charging individuals for all or part of the cost of providing CRS-covered services. Taking equipment purchased for the CRS participant with Medicaid funds without permission is misappropriation of property. Misappropriation may also be a crime and the provider or Medicaid agency should consider reporting it to the appropriate law enforcement agency.
- Errors in medical or medication management by CRS providers that result in a significant adverse reaction requiring medical attention in an emergency room, urgent care center or hospital.
- Unexpected and urgent emergency room, hospital or urgent care visits or hospital admissions for any reason to treat injuries or medical conditions that were not previously known and could not be anticipated. The use of these services may be the result of substandard care, inadequate supervision by staff, or errors made by staff supervising or serving the CRS participant. Excludes admissions for known conditions that could be predicted or are covered in the person’s individualized service plan, and urgent care clinic visits for acute physical health issues.
- Overdoses of non prescription medications, misuse of prescription medications, use of illicit controlled substances or misuse of alcohol.
- The initiation of an investigation by law enforcement authorities or learning that such an investigation has been ongoing when the investigation involves an event or allegation that involves a CRS participant either as a perpetrator or victim of a crime, unless calling in law enforcement is a component of an approved crisis or treatment plan.
- The actual arrest or incarceration of the CRS participant or of a provider serving a such participant. For providers, includes only those situations when that provider was performing their role as service provider or for acts previously performed while in the role of service provider. Providers involved in criminal activity not related to the provision of services that occurred outside of the person’s employment are not reportable incidents but must be dealt with as a change in provider qualification status.
- All suspected or confirmed suicide attempts by a CRS participant.
- A fire in the home or facility in which the participant lives or the place the participant was receiving services such as a day service program if the fire resulted in a response by a fire department.

- Significant damage to the participant's property, the property of service providers, the participant's residence, the participant's place of employment, or where the participant receives service or other place the participant frequents if the property damage was caused by or is suspected to have been caused by the participant and/or if the damage poses or posed a threat to the participant's health, safety or welfare. Includes significant damage that is the result of acts of nature such as storms, earth quakes, meteors or asteroids.
- The presence of unsafe or unsanitary environmental conditions in a person's home or a place the individual frequents including the place the individual works or receives services.
- Use of isolation, seclusion, or restraint (physical or chemical) by a service provider in violation of s. 51.61 WI Stats., DHS 94.10, without county and the Department's prior approval, or in a manner not consistent with the department's approval, including proper use of restrictive measures when done under emergency conditions as defined in the Guidelines for the Approval of Restrictive Measures (see Appendix R).
- Unreasonable confinement or restraint of an adult by service providers or others including the intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his or her living area, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with state and federal standards governing confinement and restraint. [WI Stat. 46.90(1)(i)]
- Unanticipated absence of a participant whose assessment and individualized service plan indicate the need for and provision of ongoing supervision. Absences may include wandering off or intentionally leaving the place the person is supposed to be, thereby placing the participant at risk of harm.

V. How is an Incident Reported?

Incident reporting is always a person-specific process. If an incident involves or affects multiple CRS participants, a separate report must be submitted for each participant affected by the incident. For example, if a staff person in a group living situation abuses one person, one report is required. If that staff person leaves all CRS participants in the same living situation with no supervision because he or she left the building, a separate report is required for each affected participant.

Incident reporting is part of a larger incident response process described in Chapter 8 of the CRS Provider Manual. The process begins when the Medicaid agency, service provider or guardian or family member observe or learn of an event or discover a situation that conforms to the definition of incident contained in the previous section of these instructions. The provider and/or Medicaid agency must determine what has or may have occurred, whether the CRS participant is in any immediate danger or risk, what the most appropriate response might be and who should respond to the situation. The response by provider or Medicaid agency staff must begin by eliminating any danger and/or risk from the situation so the CRS participant is safe. This should then be followed by a more permanent resolution of the situation. Providers and guardians or family members must inform Medicaid agencies of such incidents and Medicaid agencies must both notify and report the event and the response to the assigned state and/or Quality Assurance contact as specified below.

State contacts serve as resources to Medicaid agencies and can often serve a liaison function with other units in the Department or state government (e.g., Division of Quality Assurance (DQA) or Department of Children and Family Services). State staff may also get involved by assisting with increased on-site short-term monitoring of some situations. Incident follow-up may be completed quickly or may involve a longer period of time if a number of corrective actions must occur. The incident investigation may also lead to follow-up monitoring by both county and state staff to determine if the situation has stabilized and if plans of correction have been successfully completed.

Reporting incidents may involve two actions—notification and reporting. **Notification** is an immediate communication to the Medicaid agency, state contact, or both when an incident is considered critical, active, ongoing and one that places the individual at risk. For both providers and Medicaid agencies, notification means promptly letting the designated contact know the basic facts of the incident and how it is being handled. For providers, this involves informing the Medicaid agency of the incident. Notification is intended to make the designated state staff or Medicaid agency staff aware of the incident as quickly as possible. Notification should be accomplished by some form of immediate communication, typically phone call. The only written record of notification should be a file or log note by both the party doing the notification and the party receiving the notification. This date must eventually be reflected on the incident reporting form.

The need to notify and the timeline for notification depend on whether or not the incident is critical. These are discussed below under timelines and deadlines.

Reporting incidents involves the submission of some portion or all of the incident reporting form by the Medicaid to DHS. If the report is coming from a service provider, or guardian/family member, the information must be reported to the Medicaid agency in whatever format or on whatever form the Medicaid agency requires. The promptness of report depends on the seriousness, danger and/or risk involved in the incident, the urgency of the current situation and whether or not the incident is active and ongoing or involves events that occurred some time in the past. A more timely report of some of the information is expected when the incident is considered critical. The submission of a partial report follows notification and must be followed by submission of a complete report, both using the incident reporting form. Incident reports may need to be updated until the event is resolved and “closed” by the Medicaid agency.

Providers are expected and required to report incidents to Medicaid agencies. They must furnish the information needed for the required report but are not required to use the DHS form unless directed to do so by the Medicaid agency. Providers must not directly report to the department unless they are the Medicaid agency’s designated contact. Families and providers are permitted, expected and encouraged to report the incidents specified in this document to their Medicaid agency. Generally these reports go to the agency Support and Service Coordinator or to a specialized staff person designated to handle such incidents by the Medicaid agency. Agency staff (e.g., Support and Service Coordinators) are required to immediately notify and then report critical incidents to the State staff responsible for the benefit. Incidents that have been confirmed to have occurred or exist as well as alleged critical incidents that have not yet been determined to be founded or unfounded should be reported. All incidents reported must eventually be closed. Closure is accomplished by the submission of an updated incident reporting form with the appropriate fields filled in; indicating that the situation has reached a conclusion and no further action relating to the participant is required.

VI. Overview - Why We Report These Incidents

The Department of Health Services is required by the Centers for Medicare and Medicaid Services (CMS) to insure the health, safety and welfare of home and community-based services participants. The Department assigns and shares this responsibility, in part, to/with local Medicaid agencies, service providers and guardians/family members. The CRS Manual specifies actions intended to address this assurance in Chapter 8. This chapter requires each Medicaid agency to have an adequate system to ensure CRS participants are adequately protected from physical, verbal and sexual abuse, maltreatment, neglect, financial exploitation and other events and incidents. Chapter 8 also requires agencies to report these incidents and events and to have an effective response system when incidents of this kind arise. The Medicaid agency response system is expected to have staff or agents address and resolve these situations and to decrease the likelihood of a recurrence of the incident. The state uses incident reports to identify statewide or regional patterns and trends, which allow the development of interventions to decrease the likelihood of reoccurrence of such incidents.

VII. Timelines and Deadlines

Critical incidents—Incidents that are active and urgent are considered “critical,” and must be designated as such on the form. Service providers and guardians/family members must notify the local Medicaid agency immediately of such incidents. Notification to the Medicaid agency should be within 24 hours.

Local Medicaid agencies must notify the state contact of the incident within three business days (generally 72 hours) following the discovery of an incident, via telephone.

Fields 1-34 of this form must be completed and submitted within seven days of the notification. If the incident occurred sometime in the past and no current risk exists, immediate notification is not required and the completed form, all fields, may be submitted to the appropriate contact 30 calendar days from the date the incident was discovered. For critical incidents, any additional information not available at the time of the initial report may be submitted within 30 days of the incident or when the report is complete. Additional material/information that was not immediately available due to reasons beyond the Medicaid agency’s control may be sent by e-mail or under cover letter at a later date. Personally identifiable information on this form is collected for the purpose of improving quality of services and will only be used for that purpose. All incidents must eventually be closed with the “review closed” report in field 12 checked off.

VIII. Definitions

- A. **Abuse** means any of the following:
1. An act, omission or course of conduct by another that is inflicted intentionally or recklessly and that does at least one of the following:
 - a) Results in bodily harm or great bodily harm to the individual.
 - b) Intimidates, humiliates, threatens, frightens or otherwise harasses the individual.
 2. The forcible administration of medication with the knowledge that no lawful authority exists.
- Examples of abuse include:**
- mental/emotional abuse—threats of harm, name calling, blaming, ignoring, threatening to withhold personal property or denying client rights or use of tonal inflection that intimidates, humiliates, threatens, frightens or otherwise harasses the individual
 - physical abuse—hitting, slapping, pinching, or grabbing a person that causes pain or injury
 - physical abuse—use of a mechanical or chemical restraint, isolation or seclusion without prior Departmental approval
 - physical abuse—restricting the use of a mobility device or intentionally failing to provide necessary assistance for activities of daily living
 - sexual abuse—inappropriate physical contact, exposure to unwanted sexually explicit material or verbal harassment of a sexual nature
- B. **Community setting** means a public location that is not under an agency’s control such as a park, roadway, shopping center, YMCA or other public accommodation.
- C. **Death-accidental** means an unanticipated death that is the consequence of a specific negative and unintentional event such as a medical error, motor vehicle accident, airway obstruction by a foreign object or food or ingestion of a toxic substance. An accidental death is not abuse or neglect.
- D. **Death-anticipated** means a death that was medically predicted to occur within six months if only routine and comfort interventions were provided. Anticipated deaths do not include the death of a person with a life-long disability that has been reasonably stable.
- E. **Death-related to psychotropic medications** means death that was contributed to by the use or withholding of psychotropic medication, or adverse reactions to a psychotropic medication.
- F. **Death-related to restraints** means the person was either in restraints, seclusion, or isolation at the time of death or the death was directly related to the proper or improper use of restraints, seclusion, or isolation.
- G. **Death-related to suicide** means the participant intentionally placed him/herself in harm with a reasonable belief that it would result in their death.
- H. **Death-unanticipated** means a death that was not predicted or anticipated within six months, or caused by an accident. An unanticipated death may be the result of abuse, neglect, an emergency medical condition, high-risk medical procedure, or sudden decline of a pre-existing medical condition. Deaths due to ruptured bowel, cardiac arrest, pneumonia, sepsis, seizure, or stroke are examples of unanticipated deaths. If the death was related to abuse or neglect, this must be documented in the CIR.
- I. **Hospitalization-emergency** means unscheduled medical treatment needed for the sudden and unexpected onset of a medical condition that, if immediate medical attention was not received, could result in death or serious injury to the person. Please note the term “unexpected.” This is a key determinant in determining if such events are reportable incidents.
- Examples of emergency hospitalization include:**
- admission for heart attack, stroke, severe shortness of breath
 - assessment following a significant trauma event
 - significant loss of blood
 - burns or frostbite over a large portion of the body
- J. **Hospitalization-mental health/behavioral** means an unanticipated, emergency or unscheduled overnight admission for assessment or management of an unstable mental condition or because of high-risk and dangerous behaviors that require management by a physician and staff of such a facility.
- Examples of mental health/behavioral hospitalization include:**
- Unanticipated emergency detention for mental health symptoms or dangerous behaviors
 - deterioration or escalation of behavior that was not anticipated or planned for

- admission to an inpatient psychiatric unit for urgent medication adjustment

K. **Isolation** means any process by which a person is physically or socially set apart by staff from others but does not include separation for the purpose of controlling contagious disease.

L. **Law enforcement/Protective Services contact** means a participant is the subject of an investigation by law enforcement or child or adult protective services or is alleged or was the victim of an event that is reported to law enforcement.

Examples of law authority contacts that are a critical incident include:

- motor vehicle accidents where injury or major property damage occurs or driver violations that pose a safety risk to a participant **and** the participant is a passenger in the vehicle at the time of the accident or violation **or** is struck by a moving vehicle
- physical detention by law authorities of a participant for disruptive behaviors, possible or actual legal action, or parole revocation
- investigation of possible criminal activity where a participant is the victim or alleged perpetrator of a crime such as sexual abuse or assault

Examples of law authority contacts that are not a reportable incident include:

- parking tickets, minor “fender-benders,” moving violations that did not involve an accident. While these may suggest response from the Medicaid agency, that response should come in the context of provider monitoring and not incident reporting.

M. **Mechanical support** means an apparatus that is used to properly align a person’s body or to help a person maintain his/her balance, or to promote mobility. (Use of a gait belt to provide support during mobility activities is a mechanical support.)

N. **Medical restraint** means an apparatus or procedure that restricts the free movement of a person during a medical procedure or prior to or subsequent to such a procedure to prevent harm to the individual or aid in recovery or when used to protect an individual during the time a medical condition exists.

O. **Neglect means** an act, omission or course of conduct that, because of the failure to provide adequate food, shelter, clothing, medical care or dental care, creates a significant danger to the physical or mental health of an individual.

Examples of neglect include:

- environmental—failure to maintain a building, furniture and associated spaces in a clean, well ventilated, and safe condition
- environmental—failure to provide adequate sensory and mental stimulation appropriate to the participant’s needs
- failure to follow plan/poor care—failure to provide support services to an individual according to the care plan or policies and procedures or in such a limited manner that the person’s safety or health is compromised
- medical—failure to provide medication as ordered, prompt and adequate physical care, seek appropriate medical treatment or report change in a participant’s condition in a timely manner
- nutritional—failure to provide adequate and appropriate food, water or other dietary services to meet the needs of the person

P. **Physical restraint** means a manual hold by a support worker or use of an apparatus other than a medical restraint or mechanical support that interferes with the free movement of a person’s limbs or body, which the person is unable to remove easily.

Examples of physical restraint include:

- a locked room
- a device or garment that interferes with an individual's freedom of movement and that the individual is unable to remove easily
- restraint by a facility staff member of a participant by use of physical force
- disabling or interfering with a participant’s use of a mobility device
- withholding assistance to a dependent person for the purpose of interfering with the person’s free movement

Q. **Provider** means any person or agency that is paid by Medicaid, county, private, or public funds for providing a service to the person.

- R. **Psychotropic medication** means an antipsychotic, antidepressant, lithium carbonate, or a tranquilizer.
- S. **Response summary** means actions taken by the person/guardian, county or providers in response to the event or allegation.
- T. **Restraint** means any device, garment or physical hold that restricts the voluntary movement of or access to any part of an individual's body **and** cannot be easily removed by the controlled individual.
- U. **Seclusion** means physical or social separation from others by provider not including separation to prevent the spread of a communicable disease or cool down periods in an unlocked room as long as the person's presence in the room is voluntary.
- V. **Service provider**, in this context, means a person who is providing paid or unpaid service or support pursuant to the person's individualized service plan. Service providers may be the person in contact with the CRS participant or someone who supervises the people in direct contact with the participant.
- W. **Suicide** means the act of taking one's own life voluntarily and intentionally.
- X. **Unanticipated absence** means a participant's whereabouts is unknown and he or she is considered missing.